DOCUMENT RESUME

ED 139 711 SO 010 070

AUTHOR	Stokes, Bruce
TITLE	Filling the Family Planning Gap. Worldwatch Paper 12.
INSTITUTION	Worldwatch Inst., Washington, D.C.
SPONS AGENCY	United Nations Fund for Population Activities, New York, N.Y.
PUB DATE	21 May 77
NOTE	55p.; Not available in hard copy due to marginal legibility of the original document
AVAILABLE FROM	Worldwatch Institute, 1776 Massachusetts Avenue, N.W., Washington, D.C. 20036 ($2.00 paperbound, quantity discounts available)
EDRS PRICE	MF-$0.83 Plus Postage. HC Not Available from EDRS.
DESCRIPTORS	Adult Education; Birth Rate; Community Role; *Contraception; Developing Nations; Family Life Education; *Family Planning; *Global Approach; Government Role; Parents; Peer Relationship; *Population Trends; *Program Effectiveness; *World Problems

ABSTRACT

The author provides a global review of family planning techniques and their impact on national birth rates. Sterilization, the pill, and intrauterine devices are the most popular methods of contraception worldwide. Abortion, where it is legal, is also extremely popular. In countries such as the United States where population control is not an urgent concern, there is a need to educate young people about contraception, make devices readily available, and eliminate the social stigma that birth control is an untouchable subject. In developing countries with critical population problems, family planning action is required on several fronts. Decentralized programs have shown greatest success. These programs combine increased supply of devices and motivation in the form of peer reinforcement and educational efforts. When a variety of contraceptives is made available, people seem more willing to participate in family planning because coercion by community or government seems less rigid. The author describes in detail successful programs in China which are the responsiblity of small groups in factories and villages. Tight community bonds are instrumental in their success. Funding needs and agencies for global birth control are discussed, as well as changing attitudes of national governments. (AV)

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Filling The Family Planning Gap

Bruce Stokes

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Worldwatch Paper 12
May 1977

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Worldwatch Institute is an independent, non-profit research organization, created to identify and to focus attention on global problems. Directed by Lester R. Brown, Worldwatch is funded by private foundations, United Nations organizations, and governmental agencies. Worldwatch papers are written for a worldwide audience of decision makers, scholars, and the general public.

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Library of Congress Catalog Card Number 77-78349
ISBN 0-916468-11-9

Printed on recycled paper

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More than half the world's couples go to bed each night unprotected from unplanned pregnancy. For more than 300 million couples the fundamental decision of whether or when to have a child is seldom a real decision at all. Few of these men and women have adequate information about the health implications of ill-timed childbearing; few receive feedback on the impact of their fertility decisions on their community; and few have access to modern family planning methods. To narrow this family planning gap, many governments have begun to decentralize family planning programs, extending services and using peer pressure to promote the acceptance of contraception and of small families.

More couples are effectively planning their family size than ever before. In the first half of this decade, the use of oral contraceptives, intrauterine devices (IUD), and both male and female sterilization—the three most effective means of preventing unwanted pregnancies—rose markedly in both rich and poor countries. Yet, despite dramatic progress, a majority of couples still do not use these methods. Primitive contraceptive practices and old prejudices against contraception remain. Archaic laws make contraceptives and safe abortion difficult to obtain. Family planning's disenfranchised minorities—the poor, the young, the unmarried, and the rural—still cannot time and space their childbearing effectively.

The exact number of couples in the world who need family planning services to avoid an unplanned pregnancy is difficult to assay with any certainty. At any one time, about a fourth to a third of a country's female population of reproductive age (ages 15-44) is pregnant, interested in becoming pregnant, or unable to bear children. This portion differs somewhat among societies, depending on age structures and birth rates.

The author wishes to thank Martin E. Gorosh, Marshall Green, Michael Henry, K. Kanagaratnam, David Korten, Deborah Oakley, Phyllis Piotrow, J. Joseph Speidel, Jack Sullivan, Michael Teitelbaum, and Robert S. Wickham for reviewing the manuscript.

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Thus, somewhere between two-thirds and three-quarters of the females of reproductive age in any nation face the possibility of an ill-timed or unwanted pregnancy. According to Joy Dryfoos of the Alan Guttmacher Institute, this portion totaled about 30 million women in the United States in 1975, nearly 70 percent of whom were protected by some form of contraception. Approximately 500 million women in the world in 1971, the International Planned Parenthood Federation (IPPF) contends, were fertile, not pregnant, and not interested in becoming pregnant. Fewer than one-third of these half a billion women were protected by contraception, and half of those who were used unreliable methods. Since this IPPF survey was taken, family planning programs have expanded considerably, especially in China, Thailand, Indonesia, the Philippines, and Colombia. While the number of women threatened by unwanted or unplanned pregnancies may have been reduced somewhat by these efforts, more than 300 million women, and thus couples, still use no family planning methods at all.[1]

Certainly, the record of legal and illegal abortions each year testifies to the fact that too many family planning decisions are made after the fact. In one El Salvador hospital, J. Mayone Stycos of Cornell University reports, one of every five women admitted suffers from complications arising from the illegal termination of a pregnancy. In Moscow, two abortions are reported for every live birth. Women under 20 bear a surprisingly large portion of all babies in rich and poor countries alike, despite evidence that postponing first pregnancies past adolescence reduces maternal and infant mortality and illness. An 18-county study in 1974 in upstate New York showed that 43 percent of all births were mistimed or unwanted. In disparate ways, the number of ill-timed pregnancies and widespread reliance on abortion among all social classes and groups signal an unmet need for contraception.[2]

Economic and social conditions deny many couples access to family planning services. Official programs in developing countries have rarely reached the poorest of the poor. Even in countries where contraceptive use is widespread, the poor are often the last to receive family planning services. In West Germany in 1974, only six family planning clinics served the 2.3 million low income foreign workers in

the country; yet, every sixth baby born in Germany had at least one foreign parent. In the United States, racial minorities, among the most disadvantaged groups in the society, have the highest rates of unplanned pregnancies. The wives of manual laborers in Britain are, studies show, less likely than the well-to-do to use contraception and more likely than the well-off to rely on the least effective methods. Using outdated contraceptive techniques, principally withdrawal and the rhythm method, even the most conscientious often fail to avoid pregnancy.[3]

The young—both married and single—face particularly difficult barriers in their efforts to obtain information about contraceptives and to protect themselves from unwanted pregnancy. Thirteen million women around the world who bore children in 1975 became mothers before they became adults. In the United States during the same year, about one million teenagers became pregnant; they added 600,000 persons to the population and collectively lost approximately 6,000 infants who might have lived if their mothers had waited until they were 20 years old to bear children. Only 30 percent of the never-married sexually active teenagers who were canvassed by Johns Hopkins University researchers in 1976 reported using some method of birth control regularly. Seventy percent of the sexually active adolescent women who did not use contraceptives told interviewers conducting a similar study that precautions were unnecessary because they thought they could not become pregnant. Such ignorance often ends in abortion. Women in their teens have one of every four abortions in Great Britain, Sweden, and Australia.[4]

Many couples marry young and have one or two children while still in the second decade of life. While raising the legal age of marriage might help delay childbearing in some societies, custom may defy law. Common law marriage and pre-marital childbearing, accepted practices in many societies, contribute to the problem of adolescent pregnancy. The dissolution of traditional communities and the flight from the countryside to cities, especially in developing countries, have weakened many moral injunctions against pre-marital sexual relations and may have increased the number of births to unmarried teenagers.

Yet as taboos about sex crumble, objections to sex education persist. Few countries teach the young about reproduction and sexual responsibility, and only in Sweden is sex education deeply entrenched in the curriculum. Many American school districts actually prohibit such instruction. Indeed, both information and family planning services are largely out of reach of the young. By the end of 1975, only 26 states and the District of Columbia in the United States had granted adolescents the legal right to obtain contraceptives. Today's teenagers are ushered into a world of tempting sexual freedom that all too often becomes a trap because family planning programs are inadequate.[5]

The urban bias of most organized birth control programs is universal, even in an avowedly rural-oriented, egalitarian society like China. In 1974, the Planned Parenthood Federation of America estimates, 2.5 million women in non-metropolitan areas in the United States had no access to any family planning services—private physicians or organized clinics. A study in 1975 in France by the *Mouvement Français pour le Planning Familial* revealed that few country-dwellers had access to the government's family planning clinics. While the portion of the world's population living in rural areas is falling, those in the countryside in most developing nations and in parts of eastern and southern Europe still represent the majority and still tend to have large families. "There is never more land, only more children," a Chilean peasant woman told an International Labor Organization observer in the early seventies; her words evoke the harsh rural realities of insufficient land and inequitable land distribution, problems that too many claimants on a family's patrimony only exacerbate. Providing family planning services to those in rural areas may be more difficult than reaching needy couples in the city, but the rural demand for assistance in planning births is no less pressing than the urban one.[6]

Couples often face the threat of unplanned pregnancies because access to modern contraception is limited by law. Prescription requirements inhibit use of the pill in India, and the Japanese government permits doctors to prescribe the pill only to regulate menstrual disorders. Laws in many West African countries impede or forbid the sale and distribution of contraceptives—a legacy of French colonialism that

"Today's teenagers are ushered into a world of tempting sexual freedom that all too often becomes a trap because family planning programs are inadequate."

has survived France's domestic about-face on the issue. In Algeria birth control is available only to mothers with four children. Many governments view sterilization as an extreme form of family planning and deny this option to the young, even to those who have several children. Customs duties, manufacturing and quality controls, and advertising regulations often so limit the availability of contraceptives that people infer that their government opposes family planning, even if it is officially neutral on the subject. Industry's codes of practice disallow advertising contraceptives on radio or television in the United States.[7]

For couples bent upon planning and spacing their families and for governments eager to slow population growth, reducing the family planning gap is not merely a matter of using or providing some form of contraception. It is also a question of choosing or promoting the most reliable and safest birth control methods. Where ready access to modern contraceptive techniques is provided, the highest portion of couples use contraception. In the United States, Australia, Japan, and England and Wales, more than 60 percent of all married women regularly use contraceptives. Over the years, the preferences of women in these countries have gradually changed; and as more effective means have become available, they have replaced the rhythm method and withdrawal. (See Table 1.)[8]

Taken together, the most effective contraceptive methods are increasingly popular in the English-speaking world and account for more than half of all contraceptive use. Concern over health risks associated with the pill does not seem to have seriously affected oral contraceptive use in these countries, although U.S. women are more likely than their British and Australian counterparts to use the pill for a while and then to shift to other methods. Sterilization is growing in acceptance and its use has doubled in the United States in just 10 years. These trends hold for all industrialized nations except Japan; there, the pill is difficult to obtain, the IUD was illegal until 1974, and sterilization is not widely accepted. Japan's success in slowing population growth reflects the popularity of the condom, the use of which is effectively backed by a liberal abortion law.

Table 1: Contraceptive Practice in Selected Developed Countries Among Couples of Reproductive Age Using Contraception

Country	Pill	IUD	Sterilization	Condom	Other
			(percent)		
United States (1973)	36.0	9.6	23.5	13.5	17.4
Japan (1975)*	3.0	8.6	4.7	77.8	50.9
Australia (1971)**	38.0	8.0	—	9.0	45.0
England and Wales (1972)***	58.0	1.0	—	25.0	23.0

Dash indicates data not available.

*Two responses were allowed, so total exceeds 100. **Melbourne. ***More than one response was allowed, so total exceeds 100. The survey was among recently married couples.

Source: Charles F. Westoff; Population Problems Research Council; Australian National University; and J. Peel and G. Carr.

Among the larger developing countries, China has the most widespread use of contraception. While exact data are unavailable, the IPPF estimates that 35 percent of all married Chinese couples practiced contraception in 1971. Figures for the Shanghai municipality in 1971 given to Pi-chao Chen, one of America's foremost observers of Chinese family planning, indicate that 70 percent of couples used contraception in Shanghai even before the government expanded family planning services in the early seventies. All who have observed the Shanghai program agree that it is decidedly more advanced than efforts in the Chinese countryside, where modern contraceptives have become available only in recent years. While estimates of rural and urban use differ greatly, reports from several large cities indicate more than half of all urban couples of reproductive age use contraception, a level of use that compares favorably with that in North America, Europe, and Japan.[9]

To fulfill its desire to slow population growth rapidly, the Chinese government has made a full range of contraceptive methods available. According to reports pieced together from various travelers in China, sterilization may be the most popular method of limiting family size.

Table 2: Contraceptive Use in Shanghai Among Couples of Reproductive Age Using Contraception, 1971

Method	Percent
Pill	19
IUD	10
Condom and diaphragm	17
Female sterilization	44
Male sterilization	10
Total	100

Source: Pi-chao Chen.

Among methods whose effects can be reversed, the pill has gained precedence over the IUD in recent years, as the figures indicate. (See Table 2.) The Chinese were the first in the world to experiment with a low-estrogen pill, which is often impregnated on edible rice paper; but how extensively the paper pill is used is not known. Abortion is available on request in China, and no stigma seems to be attached to its use as a fall-back when contraception fails. Overall, the government appears to be making every effort to expand family planning.[10]

Studies of contraceptive use in poor countries other than China are sketchy at best. The data that do exist are for nations with well-established family planning programs. (See Table 3.) Taken alone, these statistics often show rapid growth of contraceptive use and great dependence on modern methods. But since these countries are too few in number to be truly representative and since all such figures are mere estimates, contraceptive-use statistics for these countries should be viewed cautiously; they serve best as indicators of relative trends.

In Hong Kong and Singapore, most women get their contraceptives from official programs and many use effective methods. Nearly half of all couples rely on the pill, the IUD, or sterilization; and, predictably, birth rates have fallen in the last decade. The portion of married

Table 3: Contraceptive Use in Selected Developing Countries Among Couples of Reproductive Age

Country	1969	1970	1971	1972	1973	1974	1975	1976
					(percent)			
Hong Kong	42.0	50.0	51.0	54.0	52.0	55.0	57.0	61.0
India	8.0	12.0	—	13.2*	13.6*	15.1*	15.8*	16.9*
Philippines	—	—	8.1	11.0	15.0	—	—	21.7
Singapore	37.0	45.0	—	—	—	60.1	—	77.1
South Korea	25.0	32.0	—	30.0	—	30.5	34.0	34.2
Thailand	7.4	7.6	9.6	18.7	25.7	24.8	26.6	32.0

Dash indicates data not available.
*Government family planning program only.
Source: Population Council.

women ages 15-44 using contraception exceeds 50 percent and approaches that in most developed countries. Family planning programs in Thailand and in the Philippines have yet to reach a third of those in need; yet, the portion of married women using contraception mushroomed from 8 to 32 percent in Thailand and from 8 to 22 percent in the Philippines between 1970 and 1976, according to estimates reported by Dorothy Nortman of the Population Council. Preliminary data for Colombia show similarly impressive trends; Jerald Bailey of the Population Council estimates half the married women in Bogotá used contraception in 1974, almost twice the number of those who did so in 1964. About 30 percent of all Colombian couples, the 1976 census suggests, practiced contraception. Similar impressive but preliminary figures exist for Indonesia. In East Java and Bali, sites of new family planning programs, 34 percent of married couples used contraception by January 1977. On the other hand, only one in six married women in India used contraception by 1976, despite the Indian government's two decades of involvement in family planning.[11]

The poorly organized, poorly funded family planning programs that exist in most poor countries cannot be expected to attain overnight contraceptive use at the levels prevalent in Hong Kong and Singapore.

Fewer than one in ten couples in Africa, in the Middle East, and on the Indian subcontinent used contraception in 1971, the IPPF estimated; indeed, contraceptive use had increased little in these areas by 1976. Some critics charge that this dismal performance indicates that family planning programs will never succeed. But the record in Thailand and in the Philippines demonstrates that poor countries can get family planning programs off the ground.

Overall, the birth rates in countries containing fully 40 percent of the world's population fell significantly between 1970 and 1975. Yet in nations with 60 percent of the planet's population, birth rates changed little. Why some birth rates fell while others did not is not readily apparent; a simple causal relationship between falling birth rates and the availability of family planning services cannot be established. But it is evident that in countries where birth rates have fallen, family planning programs are extensive or expanding; and where birth rates have remained high, family planning programs are often woefully inadequate.[12]

The relationship between birth rates and family planning is readily measured using a rule of thumb suggested by Bernard Berelson, President Emeritus of the Population Council. Countries with 30 percent of their population using contraception, he contends, have a birth rate close to 30 per thousand; for every two points difference in the percentage using contraception, the birth rate usually changes by about one point. For example, South Korea's 34-percent contraceptive use rate corresponds roughly to its birth rate of 28 per thousand.[13]

As using Berelson's formula suggests, a society and its individual families both can begin to experience some of the advantages of reduced fertility long before the national majority practice contraception. In most African, Asian, and Latin American countries, where birth rates range from 35 to 50 per thousand, family planning programs cannot immediately cover all women at risk of unplanned pregnancy. However, reaching a third of those in need could bring birth rates down to about 30 per thousand, improving maternal and infant health and relieving pressure on the domestic economy, the environment, and the social fabric. Filling even that portion of the family planning

gap poses a challenge. Yet, with the success of several programs on record, setting a one-in-three goal for 1985 does not appear unrealistic for many countries.

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A Smorgasbord of Services

Once a collection of folk myths, family planning has become a science and a business. As interest in controlling fertility has grown, a wide variety of techniques and methods has evolved; some are adaptations of age-old practices, others products of recent research. The legalization of abortion, the growing reliance on sterilization, and the slow but steady increase in the number of women using oral contraceptives all argue that many couples do want and seek out a choice of family planning services.

The first family planning campaigns all too often relied solely on one method and on one means of distribution; they also often ignored local prejudices, taboos, and concerns. In 1965, the Indian Government made the IUD the foundation of its birth control program; but by 1969, efforts to enamor Indians of the IUD collapsed in the wake of reports of medical complications, a blow the already troubled family planning program could scarcely withstand. Similarly, the Catholic Church's early prohibition of all means of birth control except the rhythm method has until recently stalled effective family planning in predominantly Catholic Latin America.

While the idea of providing a smorgasbord of family planning services was first suggested in the early sixties, only in the mid-seventies did this approach take hold. Almost obvious, the theory is that the most effective distribution schemes are sensitive to various types of demand. In the commercial world, several brands of cola are often manufactured by the same company, a practice that both responds to and creates demand. But providing couples with a choice of contraception is not merely a matter of good salesmanship. Choice gives the user a sense of personal control over his or her fertility, and choice born of variety encourages widespread community involvement in

"By early 1976, nearly two-thirds of the world's women had the right to legal abortion."

family planning—the corner greengrocer can sell condoms and the neighborhood paramedic can dispense the pill. As the means of limiting family size are tailored to individual preferences, contraception can become more acceptable and accessible to all couples.

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Before the modern era, family planning meant withdrawal, primitive abortions, and various concoctions reputed to prevent pregnancy. The ancient Egyptians used alligator dung as a spermicide. The English in Elizabethan times thought that covering the penis with tar before love-making would make conception impossible. Like their maternal ancestors, women in many parts of the world still swallow potions to induce miscarriages or use sharp instruments to abort unwanted fetuses.

While today abortion is no longer primitive or dangerous where it is legal, it is possibly the most commonly used non-permanent method of averting birth. Estimates of the number of unwanted pregnancies terminated each year by abortion range from 30-55 million. Where other means of limiting family size are difficult to obtain, abortion is particularly prevalent. In Brazil, an estimated half of all conceptions end in abortion. In Egypt, as many as 500 illegal abortions are performed every day.[14]

Aware that prohibition does not prevent practice, many governments have shifted their positions on abortion during the seventies. At the beginning of the decade, 38 percent of the world's people lived in countries where legal abortion was readily available. By early 1976, laws had changed in dozens of countries, and nearly two-thirds of the world's women had the right to legal abortion. Unfortunately, even where abortion is legal, abortion services are not always available. Although the United States Supreme Court established in 1973 a woman's right to abortion on request during the first six months of pregnancy, many U.S. hospitals—particularly those in non-metropolitan areas—have no abortion facilities whatsoever. Planned Parenthood's Alan Guttmacher Institute estimates that in 1975 as many as 770,000 women who had unplanned pregnancies and who may have wanted abortions could not obtain them.[15]

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Where abortion has been legalized, its impact on population growth and maternal health shows. After Japan made abortions legal in 1948, the Japanese birth rate fell by a third in five years. Now one abortion is performed for every live birth, and abortion is contributing to the gradual decline in Japan's birth rate. In the United States, approximately one in 14 women of reproductive age has had at least one abortion. Over a million such operations were performed in 1975, making abortion one of the most commonly performed operations in the country and slowing U.S. population growth by about a quarter. In 1969, when abortion was illegal in New York, 6,500 women were admitted to municipal hospitals with post-abortion complications. By 1973, three years after abortion was legalized, half that number of medical complications were reported.[16]

Means of ending pregnancy have been vastly simplified in recent years. Some techniques now in use permit the process to be handled in outpatient clinics or by trained persons traveling from village to village. The vacuum-aspiration procedure, a method widely used for early termination of pregnancy, requires just the simple use of a hand-held, hand-operated, oversized syringe. Menstrual extraction, a mini-abortion that induces menstruation within a few days of the time a woman misses her first period, may also hold great promise since it requires only simple equipment and can be performed by paramedical personnel—an important consideration in doctor-short countries. While abortion is one of the most common means of fertility control, it remains an expensive and, where illegal, often dangerous form of family planning. For this reason, ever more couples are turning to preventive family-planning measures.

Attempts to estimate the number of couples using each kind of contraception are fraught with dubious assumptions and are highly controversial. Little hard data exists even for the developed countries, and those making estimates sometimes develop figures that tend to support their pet programs. Table 4 is the product of an attempt to help fill that information gap with admittedly imprecise estimates of the use of various contraceptives in 1970 and 1976. As Sallie Craig Huber wrote in 1973 when IPPF published similar estimates, "This survey is a strictly practical rather than academic exercise, designed to pre-

sent the best picture possible at this point in time. We hope our mistakes will be seen by others as a challenge to make better guesses, to make good deficiencies by further study and, generally, to correct them."[17]

Table 4: Estimated Number of Couples Controlling Their Fertility by Family Planning Method

	1970	1976
	(millions)	
Sterilization	20	75
Pill	30	55
Condom	25	30
IUD	12	15
Other	60	65
Total	147	240
Abortion	30-55	30-55

Source: AID and the Population Council.

Voluntary sterilization is truly the contraceptive phenomenon of the seventies. Although it was once regarded as an extreme and undesirable form of birth control, the number of couples using sterilization now exceeds the number of those using any other single preventive family-planning measure. In 1950, no more than four million couples in the world depended upon sterilization to control their fertility; in 1975, four million sterilizations were performed in Europe alone. In Korea, 13 percent of all married couples using contraception have chosen sterilization. In the United States, the figure is nearly 25 percent; in Puerto Rico, one of three couples relies on it. Some 75 million couples around the world now use sterilization as a family planning method.[18]

In Europe and North America sterilization is legal or unregulated everywhere except in Italy, France, Turkey, and some Canadian prov-

inces. Despite the Vatican's absolute ban in late 1976 on sterilization to prevent pregnancy, increasing numbers of female sterilizations are being performed in Latin America, particularly in Colombia. In Sri Lanka, the large tea estates have established incentive programs to encourage workers to be sterilized once they have built their families.[19]

After emphasizing various contraceptive techniques with limited success, the Indian Government in 1976 made sterilization a cornerstone of their crash program to reduce average family size; by the end of the year, over seven million sterilizations had been performed, and such an unprecedented effort had proved difficult to administer. Attempts to compel individuals to have the operation led to objections on the grounds that human rights were being violated; and coercive action to meet quotas set off several violent political demonstrations. Reportedly, some local disease immunization programs failed because people feared they might be forcibly sterilized when they showed up for their shots.

Ultimately, the Indians came up against a variant of Gresham's Law—reliance on a massive, at times compulsory, sterilization program undermined public support for voluntary family planning efforts. Opposition to the sterilization program helped unseat the ruling Congress Party in the Spring 1977 national elections, and the new government promised to halt all coercion and cash incentives for sterilization and to expand condom and pill distribution. India's insistence on pushing only one family planning method may have once again set back family planning in that country.[20]

Despite this backlash, the number of sterilizations performed around the world should continue to grow, largely because the surgical procedure involved has been simplified. In the late sixties and early seventies, vasectomy was the most popular form of sterilization, because female sterilization required major abdominal surgery, general anesthesia, and several days of hospitalization. At the Indian sterilization camps in the states of Kerala and Gujarat in 1971, where several hundred thousand operations were performed in short intensive campaigns, vasectomies accounted for almost all the sterilizations performed. Without significantly curtailing interest in the male operations,

new surgical methods such as the minilaparotomy (an operation done near the bellybutton) have simplified female sterilizations. They now constitute an important part of family planning programs in the Philippines and Thailand and have surpassed vasectomies in popularity in the United States.

Especially in developing countries, where medically trained personnel are at a premium, the advent of simplified procedures means that sterilization can be moved out of the hospitals and into the villages. Some new methods are so simple that in one program in Bangladesh, village women, many of whom are illiterate, have been able to learn the technique and perform tubectomies. Their success has been striking; their patients have a lower infection rate than do the patients of trained doctors. This project suggests sterilization may well become even more common in the future.[21]

The pill closely trails sterilization as a preferred contraceptive. According to the Agency for International Development (AID), 55 million couples were controlling their fertility with oral contraceptives by late 1976. Among women in western industrialized countries the pill has overwhelming popularity, and its use seems to be on the rise on all continents. In countries just developing family planning programs, the pill is often the standard-bearer of the new contraceptive revolution.

However, in well established programs in Korea, Taiwan, Hong Kong, Singapore, and Egypt, the number of women accepting oral contraceptives has leveled off or declined. Although the pill remains the main form of contraception in many countries, growing concern over health complications with its use has prompted some women to try other methods. Soviet doctors reportedly advise against the use of the pill, and many women in the United States have begun to rethink the unknown costs associated with the pill and to switch to sterilization or the diaphragm. Only time will tell if this pattern will be repeated in poorer societies.[22]

The condom, the oldest and simplest means of contraception, has recently gained new respectability, and is now used by an estimated

30 million couples. Long considered unreliable, inconvenient, and demeaning to a man's virility, condoms of every hue and shape are now a staple of many family planning programs. In India, Sri Lanka, Kenya, and Thailand, efforts to step up the marketing of contraceptives through commercial outlets have increased condom sales markedly. Wherever women are demanding that men take equal responsibility for birth control, the condom is being welcomed back. In cultures in which the male makes all major family decisions, the availability of a contraceptive that the man controls often wins acceptance for a family planning program.

Other means of contraception have been less widely adopted. The IUD, once thought to hold great promise for women in the developing world, has only about 15 million users worldwide. After the device initially proved successful in the United States and Taiwan, family planners touted the IUD as an effective method free of the drawbacks of regular pill or condom use; but the intrauterine device has never lived up to these expectations. In most countries, well below 10 percent of all women of reproductive age use the IUD. For some women, IUDs have worked well. Others have experienced unsettling side effects—pain, irregular bleeding, uterine damage or infection, and expulsion.

A study of well-educated women in the United States suggests that the diaphragm is as effective at preventing pregnancy and as acceptable to users as more sophisticated contraceptives. One year after the test began, only one out of five women given the diaphragm discontinued using it, a smaller percentage of dropouts than for any other contraceptive method. Moreover, the low frequency with which those studied accidentally became pregnant challenges the entrenched notion that the diaphragm is unreliable and bodes well for its wider use. In addition, a study by Christopher Tietze of the Population Council indicates that the diaphragm or the condom, backed up by legal abortion, is the safest means of contraception for women.[23]

The injectable contraceptive is one new family planning option under experiment. Already quite popular in Thailand and tried in the Philippines and Indonesia, injectables are not legal in the United States.

"The ideal family planning method would be completely safe, effective, reversible, easy to obtain and use, cheap enough for the poorest person to afford, and culturally acceptable."

Longlasting but ultimately reversible, the injectable appears attractive because it does not require repeated action or vigilance by the couple involved. Still, its health implications are not fully understood, and its acceptability in a wide range of settings remains unknown.

The ideal family planning method would be completely safe, effective, reversible, easy to obtain and use, cheap enough for the poorest person to afford, and culturally acceptable. Measured against these criteria, all known methods come up short. The most effective methods—abortion, sterilization, the pill, and the IUD—have improved greatly over time and are certainly less dangerous than an unlimited number of pregnancies and more effective than withdrawal, rhythm, or folk medicines. Yet the uncertainty of safety, cost, and adaptability argues against sole reliance on any one of these methods.

Concern over the safety of the pill dominates discussions of the drawbacks of contraceptive use. Since the public and the medical community have lingering doubts about the long-term health effects associated with pill use, women under a doctor's regular care should have a medical examination before taking the pill. But in countries where women go their whole lives without seeing a physician and where taking the pill is far safer than having a baby, regulations that require a prescription to obtain the pill may be too stringent. The thrust of the data on maternal and infant mortality associated with childbirth among the poor is incontrovertible; the pill is far safer than childbirth for women under 40. A family planning program that excluded the pill would sentence many women and infants to their graves.[24]

The pill should be among the range of contraceptives available in every family planning program. Yet, sole reliance on comparative mortality statistics to justify wholesale distribution of oral contraceptives neglects the human dimension of birth control. Women, not statistics, take the pill, and some of these women experience bleeding, cramps, mood changes, and skin problems in conjunction with the use of oral contraceptives. Rumors about such medical complications, often grossly distorted, can travel like wildfire in any community, and experience with the IUD in India and with declining pill use in many

developing countries only underlines the importance of assessing and anticipating potential backlash to pill use before a family planning program is built around it.

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As a World Bank study of family planning projects noted in 1976, however, few experiments on the health implications of distributing unprescribed pills in developing countries have been conducted. Without substantial testing, the impact of prolonged pill use by women in poor areas simply cannot be determined. Even in the developed world, the pill's lifetime effects have not been fully studied, since oral contraceptives have been used for less than one generation. Applying to frequently undernourished and genetically different women in developing countries what is known about the reactions of American and European women to the pill could create problems.[25]

Only $120 million was spent worldwide in 1974 on the study of the human reproductive system, on tests of the safety of current family planning methods, and on the development of new contraceptives, such as a male pill and a pregnancy vaccine. That only three male family planning techniques exist, two of which are ancient and one of which cannot be reversed, suggests that male contraceptive research is a virgin field. Yet male fertility is biologically much more complex than female fertility, and no new male contraceptive is likely to emerge soon. Similarly, no research breakthroughs on female contraception are imminent. The lack of medical understanding about the long-term effects of the pill on the human body argues forcefully for greater research.[26]

Those who develop family planning programs must also address the issue of contraceptive supply. The U.S. government is fast becoming a major supplier of contraceptives, providing 70 percent of the condoms and seven of every eight monthly pill cycles dispensed by international agencies to more than 60 countries in the developing world in 1975. These figures mask the fact that many industrial nations provide contraceptives through bilateral assistance. Nevertheless, many observers question the wisdom of a supply system that could be crippled by the political whimsy of the U.S. Congress, undoing years of public education and field work in the best programs.[27]

Many family planning methods require an ever-expanding supply of contraceptives—a steady drain on foreign reserves in poor countries. If costs are to be internalized, the source of supply stabilized, and the impact of imports on domestic economies minimized, contraceptive production must increasingly be shifted to the developing world. Condom-manufacturing operations have already sprung up in most Asian countries, and Indonesia has met all of its own IUD demand since 1974. Mexico, India, and Cuba all have the raw materials and the pharmaceutical industries capable of meeting a growing portion of their oral contraceptive demand. Unfortunately, development agencies and private pharmaceutical industries have been slow to encourage self-sufficiency. A gradual shift of AID supply contracts to Third World producers, which would require Congressional consent, would be a shot in the arm to an infant industry; moreover, with the proper incentives, international pharmaceutical houses could lend their manufacturing and marketing expertise to their emerging counterparts in Latin America, Africa, and Asia.[28]

Where family planning programs become self-sufficient, they can better supply each segment of society with the contraceptive it prefers. The Chinese have experimented with the paper pill, developed their own IUD, and invented vacuum-aspiration abortion, all unique responses to their own needs. In Western Europe and the United States, affluence has enabled society to create multiple services that have contributed vitally to increasing contraceptive use. Whether a family planning program is aimed at the majority or at those by-passed by the contraceptive revolution, important elements in its success are the breadth of the choice of birth control methods and the ease of accessibility to those methods.

The Growing Commitment

In 1960 President John F. Kennedy expressed doubt that any U.S. President would ever be asked to sign a bill providing foreign aid for family planning. Within a decade, Washington was footing most of the bill for the international family planning effort. This turnabout in

sentiment did not confine itself in recent years to Washington. The governments of many developing nations voiced strident opposition to family planning at the World Population Conference in Bucharest in 1974. Yet, by 1976 a commitment to limit family size and to improve the human condition linked in common purpose most of the countries represented at the United Nations.[29]

Family planning at the international level has only recently received concerted support. In the early post World War II years, few global organizations, national governments, or foundations wanted to involve themselves in the extremely controversial and highly nationalistic debate over family planning. Not until the mid-sixties, when the economic health of developing nations worsened and food shortages struck in India, did the reluctance of many to give money to family planning begin to dissolve.

By the mid-seventies, most international organizations and many national governments and local communities no longer debated the role population growth plays in economic development—the urgency of slowing population growth while pushing through economic reforms had become self-evident. With unexpected vigor, countries put themselves to the task. The international community substantially increased multilateral financial assistance. National leaders—Luis Echeverria in Mexico, Suharto in Indonesia, and Ferdinand Marcos in the Philippines, among others—worked to reverse longstanding domestic pronatalist policies and set the tone for a revolution in national attitudes. At the community level, the stagnation of job markets, the frustration of personal ambitions by unexpected children, and the recurrence of food shortages all caused many who had been passed over by earlier family planning programs to begin to take childbearing out of the hands of providence.

During the seventies, family planning's budget grew substantially while new aid patterns emerged. (See Table 5.) Bilateral assistance gradually shrank over the years to less than a third of all aid. Most donors now channel their funds through the major international population organizations—the United Nations Fund for Population Activities (UNFPA) and the IPPF.[30]

Table 5: Primary Sources of Bilateral and Multilateral Population Assistance

Country or Institution	1970	1971	1972	1973	1974	1975	1976
	(millions of dollars)						
Canada	1.0	3.9	4.7	6.2	4.7	12.5	13.6
Denmark	1.4	1.9	2.0	4.0	2.4	4.0	5.0
Ford Fdn.	15.1	15.2	13.7	12.0	14.0	10.7	10.8
Japan	1.5	2.1	2.2	2.5	5.4	7.9	12.9
Netherlands	1.4	1.5	3.0	5.7	6.0	7.2	8.7
Norway	1.0	3.9	5.5	12.5	12.7	13.6	25.7
Rockefeller Fdn.	15.1	2.8	6.6	5.9	6.1	6.2	6.5
Sweden	6.5	9.2	12.7	13.7	18.3	27.4	30.6
United Kingdom	1.0	2.5	6.7	4.2	3.0	6.0	8.4
United States	74.5	95.9	123.3	125.6	112.4	110.0	135.2
West Germany	1.5	1.7	2.4	4.3	5.9	7.5	7.0
World Bank	2.0	7.8	34.4	26.5	37.0	25.0	6.8
Total	122.0	148.4	217.2	223.4	227.9	238.0	271.2

Source: AID and World Bank.

Although Washington long provided more than half of all the bilateral and multilateral resources given to Third World programs, U.S. government contributions to population projects decreased in the mid-seventies and failed even to keep pace with inflation from 1973 to 1975. In 1976 Congress showed new interest in population programs and funding rose accordingly. The major American foundations, early supporters of the population movement, have begun slowly to scale down their donations.

Fluctuations in the U.S. commitment have been offset in part by more than $10 million that 18 Arab League states have provided over a two-year period for population projects in the Middle East and North Africa. In addition, other western nations and Japan substantially increased their aid between 1970 and 1976. To date, nine of every ten

dollars disbursed by UNFPA have come from non-communist countries. The Soviet Union and the Eastern European nations have long been opposed to giving, and only Hungary and Yugoslavia have ever contributed to UNFPA.

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The demand for funding rings loud and clear from all parts of the world. In 1976, the UNFPA budget met only two-thirds of the requests for assistance it received. The amounts for which Latin American countries have asked, originally small, have increased about sevenfold in five years and reflect growing national concern over the need to integrate population planning and development activities. Asian and Latin American countries receive the lion's share of available resources and spend well over half of this money on contraceptive-distribution programs. West Africa may be the only area of the world where population planning has not made important strides in the seventies. Uninterested and even hostile, government leaders there have done little or nothing to encourage the use of modern contraception in the face of high population growth rates. The traditional pronatalist equation linking rapid population growth with economic growth lingers on in many countries.[31]

Direct bilateral population assistance has been focused on a few countries. In 1974, the largest beneficiary of direct aid was the Philippines, with $34 million; Bangladesh and India followed with $21 million and $14 million, respectively. In many countries, outside assistance often provides a substantial portion of the family planning budget. But in some countries, including Indonesia, Korea, and the Philippines, more than 60 percent of the program is domestically financed.[32]

No one knows with any certainty how much international organizations, governments, private groups, and individuals spend annually on family planning. The Alan Guttmacher Institute estimates that in the United States in 1975 the federal, state, and local governments, along with private groups such as Planned Parenthood, spent $275 million on medical family planning services. In addition, private individuals spent approximately $1.1 billion dollars on doctors' visits and contraceptive supplies. There have been no attempts to estimate total expenses on a global basis since John Robbins of the IPPF did

"President Suharto sits down every three months with his provisional governors to review their progress in expanding contraceptive services."

so in 1971. At that time Robbins reckoned that the amount spent on everything from condoms to sterilizations was in the neighborhood of $3 billion, nearly half of which was spent on abortions. While Robbins' estimate is imprecise and outdated, it is instructive to note that the $271 million spent on international population assistance in 1976 is less than 10 percent of all the money spent on family planning around the world.[33]

Governmental interest in family planning at the national level has flowered in the forms of new laws and administrative actions aimed at lowering fertility. In 1975, Asian and Pacific countries as a group adopted for the first time specific target goals and dates for reducing their birth rates; they hope to reduce average family size to two children within two decades. In 1974, Mexico and Thailand added to their constitutions provisions that promise federal support for family planning, while the Brazilian government reversed its position and endorsed its citizens' right to have access to family planning. During the early seventies, Singapore initiated a wide-ranging program of economic incentives (such as giving sterilized couples priority in the allocation of housing) and disincentives (such as limiting maternity benefits). In 1976, Philippine social security benefits were extended to cover sterilization.[34]

In Indonesia, where population growth is rapidly crowding people off the archipelago's main islands, President Suharto has taken a personal interest in family planning. He sits down every three months with his provisional governors to review their progress in expanding contraceptive services and has made the governors personally responsible for the program's success. To back up Suharto's initiative, the government has committed 40 percent of its total annual health budget to family planning.[35]

Governments have begun to dismantle the barriers that make birth planning difficult or impossible. Canada, the United States, and Germany now provide family planning services to low-income women at no cost. In Great Britain, all contraceptives are available gratis from the National Health Service. In 1975, France made these items free at government clinics. In the same year, Singapore legalized sterilization

for consenting married persons over 21 years of age. In 1976, Sweden removed all obstacles to sterilization for those 25 years of age and older. The Philippines, Pakistan, Sri Lanka, Bangladesh, South Korea, Iran, and Iraq have all removed prescription requirements for the pill. In the mid-seventies, France and Italy made advertising and distributing contraceptives legal. In early 1977, U.S. courts were reviewing the constitutionality of state laws limiting the advertising and sale of non-prescription contraceptives.[36]

Yet, the passing of a law legalizing abortion scarcely helps a pregnant 16-year-old who knows nothing of the services available to her and fears the chastisement of parents and society. To provide birth planning services to the poor, the young, the unmarried, and those in rural areas, family planning strategists have had to tailor programs to smaller groups. In the United States, Britain, Germany, the Netherlands, and Sweden, special projects have been designed to reach out to adolescents, most of whom have long been denied family planning services or have been neglected by organized programs. To help mitigate the special problems that poor working women often have obtaining contraception, the United States has experimented with family planning clinics at industrial sites, England has initiated special programs in largely working-class towns, and France has made a strong effort to reach farm women.

In developing countries, family planning programs once tended to stop at the city limits of the capital. Rural projects often failed because they were run by urbanites or by international bureaucrats, many of whom did not speak the local language and did not understand village life. Learning from these past failures, some governments have put local groups in charge of family planning programs.

As awareness of the economic, social, and environmental costs of high fertility grows, so does the recognition that couples can effectively plan their families. A unique combination of factors—the overlap of personal and community interests in decisions about childbearing, the felicitous marriage of family planning programs to self-help development projects, and the development of innovative ways to reach the majority with modern contraceptives—explains some of the new inter-

est in family planning. In turn, this interest itself suggests that the once seemingly inevitable doubling or tripling of village populations is not inevitable at all.

Like each couple, each country has attempted to reach the goal of smaller families in its own way. Some contend that within broad demographic guidelines and with the financial support of the central government, state officials will be best able to lower birth rates. In Indonesia, this approach seems effective; in India, it hasn't worked. In 1976, the Philippine Government issued a Presidential Decree calling for the creation of an Office of Family Planning in every city and municipality to do premarital counseling on responsible parenthood. The Thai Government's vigorous program uses schoolteachers to prescribe pills, and traveling medical paraprofessionals and storekeepers of all sorts to distribute them.[37]

But the most successful family planning programs in both rich and poor countries share common characteristics. In all, there is a national commitment to provide family planning services either through private medical and commercial channels or through government programs. In all, abortion, sterilization, the pill, and the IUD are universally available. And in all, individual couples' decisions on childbearing reflect the influence of their peers and their community as well as their self-interest.

Communities Take Responsibility

Traditional approaches to filling the family planning gap have not come close to meeting the need. Public family planning services were first offered in clinics. Some programs were sensitively run; but in many, persons could obtain contraceptives only by enduring considerable inconvenience and humiliation. Moreover, in Africa, Asia, and Latin America, clinics often reached only those who lived within a few miles of a facility. The difficulty the Indian subcontinent has experienced in slowing its population growth rate significantly after years of effort stands as a mute reminder of many failed attempts to control fertility.

Recently, the community has replaced the clinic as the focal point of several innovative family planning programs; and efforts to slow
30 population growth have been linked to attempts to raise the legal age of marriage, to the expansion of women's roles, and to other reforms. In several countries, contraceptives are now provided through community-based distribution systems, in which a villager who is known and trusted by his or her neighbors supplies them with low-cost contraceptives. In some nations, contraceptives are now sold in the village market, where even the poorest congregate. In addition, paraprofessional health workers now dispense pills and perform abortions. All these grassroots techniques have increased family planning's sphere beyond that of the woefully inadequate medical systems of many poor countries to encompass the everyday life of average couples.

The type of family planning work now being done at the community level and the amount of citizen participation in these programs varies by country. Creating new projects and supplying contraceptives, the government controls the program in most nations; but governments have begun to transfer to the local level some of the responsibility for distribution and user motivation. In many government-run family planning programs, new efforts to personalize services and to reach the disadvantaged are under way. In China, Indonesia, and Korea, groups of couples who collectively plan their childbearing have begun to play a new catalytic role.

Fittingly enough, the world's most organized and decentralized family planning program is in the world's most populous country, China. The Chinese family planning credo itself is concise: each couple is entitled to, but should have no more than, two or three children irrespective of personal preference, social status, or income. Family planning in China is legitimized by the oft-quoted phrases of Mao Tse-tung that pepper the discussions of the Chinese family planners and by the support of the Planned Birth Office within the State Council, the country's highest administrative body. Chinese family planners push late marriage; while marrying at 18 is legal, waiting until the combined ages of the bride and groom equal at least 50 years is rapidly becoming *de rigueur*. It is almost national dogma

in China that women can be men's equals only if they are freed from endless childbearing, so child spacing and small families are encouraged. A pension system in the urban areas and guarantees of basic necessities for childless couples in the countryside have helped lessen dependence on children for old-age security.[38]

Family planning in China is the responsibility of numerous small groups in factories, neighborhoods, and villages. Meeting once or twice a year in assemblies of 10 or 20, couples plan among themselves the number of births for their group for that year. Schooled by the need to plan locally for production, income distribution, investments, and social welfare, these groups fully understand the cost to the community of excessive childbearing and coordinate their birth plans with the targets set by community, regional, and national agencies. Once the number of births for a factory or neighborhood group has been set, the members allocate the births among themselves. Pi-chao Chen reports that couples are given priority in the following order: first are the newly married who are free to have their first child without delay; second are couples with only one or two children; and third are couples whose youngest child is nearest to five years of age. It is not known if this method of group planning, which was apparently first developed in Shanghai in the early seventies, has been fully adopted in rural areas; but travelers in China report its partial use in even the most remote provinces.[39]

The main unanswered question about family planning in China is how birth planning groups get people to agree and to cooperate. Reports of the loss of ration cards and of employment, housing, and educational sanctions against those who defy the birth planning group occasionally filter out of the country. Yet, Chinese family planning officials in countless interviews over the last five years have insisted that patient persuasion by peers, and not coercion, is the key. Indeed, tight community bonds typify Chinese society, and these have been strengthened by a mutual self-interest born of the remarkable improvement in the standard of living over the last generation. Such shared sentiments suggest that individual desires may be more easily subordinated to the will of the community in China than in most other societies. Since few countries have such cohesive forces, the

techniques that Chinese family planners use to motivate and educate people may not work well in other cultures. Surely, China's success in family planning is tied to profound social and political changes that may be difficult to repeat in other developing nations.

The ease with which the Chinese provide couples with contraceptive services influences their success in lowering their birth rate. Every governmental body or unit of industry has one person in charge of carrying on family planning education. Both men and women can obtain pills and condoms at their workplace or at home. In addition, someone in each of the courtyards around which houses are clustered in the older parts of the cities administers basic first aid and both gives out and reminds couples to use contraceptives. The national health service, paid for by the central government and the local community, provides all contraceptive services—including sterilization and abortion on demand—at no charge.[40]

The Chinese family planning system was designed to distribute inexpensive contraceptives on a massive scale within a country with meager incomes and too few trained personnel. Most observers agree that the program has been uniquely successful: it provides a full range of contraceptive services nationwide; responsibility for the success of the effort rests with those most affected by population growth; and those at risk of unwanted pregnancy have contraceptives delivered to their doors. In some form all these methods have been attempted piecemeal with mixed success in other countries. Only recently have those directing family planning programs recognized, as the Chinese apparently did, the benefits to be derived from pursuing these approaches simultaneously.

In Indonesia in the early seventies, a new sense of the urgency of slowing population growth emerged. From the office of the President on down, an awareness grew that family planning could not be left solely within the purview of the Minister of Health. Population pressure came to be viewed as a problem affecting general community development, and thoughtful Indonesians recognized that strengthening family planning meant making birth control efforts a community rather than a central-government undertaking.

"The National Family Planning Coordinating Board refit its programs to the social structures and decision-making patterns of Indonesian village life."

Originally, the Indonesian government tried to establish a clinic-based family planning program. When the program failed to increase contraceptive use significantly, the National Family Planning Coordinating Board (BKKBN) refit its programs to reflect the social structures and decision-making patterns of Indonesian village life. Since Indonesians tend to view themselves as members of a village community first and as independent individuals second, the approval of their families, their neighbors, and their friends counts for much. For centuries in Bali, family heads have met monthly to make decisions affecting the whole village. In Java, the elected or traditional headman of each hamlet commands the respect and obedience that a father in a family does. Thus, the BKKBN turned to these headmen and to these decision-making bodies for help in recruiting contraceptive users and in selling villagers on the idea of small families.[41]

In response to village women's complaints about traveling long distances to obtain contraceptive supplies, the Indonesian government established some 27,000 village pill and condom depots in Java and Bali, often in private homes. In many villages, women needing supplies simply come to the pill distributor's home periodically. In others, women assemble monthly at meetings of the local mothers' club, or *Apsari*, to buy their contraceptive supplies at nominal fees and to discuss their health problems. Often a nurse-midwife attached to the regional BKKBN attends to discuss these problems and to examine new pill users. Extensive charts and lists are kept and displayed so that every villager knows who uses each method of contraception.

That the role of the central government has helped determine the success of the Indonesian program is apparent. In most cases the *Apsari* began at the initiative of the family planning field workers, and many grew out of existing women's clubs for older women. In most villages, the government has rallied the headmen in support of the program and the *Apsari* meet in the headmen's homes under their watchful eyes. Yet, reports indicate, women attend more out of a sense of participation than out of obligation, and they bring their friends. When a woman drops out of the group or stops using contraception, the village headman is likely to call her in for a talk, and members of the *Apsari* may visit her to discuss the matter. The success of this

effort seems rooted in the shame Indonesian villagers tend to feel if they are ostracized by their community.

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The *Apsari* meetings have grown beyond mere exercises in family planning. Speakers and discussions expose women to alternative and supplementary roles to motherhood. Numerous studies indicate that the women involved have developed a new sense of village participation and take pride in community development. Several groups have started cooperative rice-savings banks, developing a food reserve for the village. Others have developed small savings and loan operations, lending money to start community gardens, stores, or to support special projects like the repair of irrigation works. Overall, the activities of the *Apsari* are closely coordinated with other cooperative development activities encouraged by the Indonesian government.

Indonesia's family planning program is neither a populist undertaking in the midwestern American tradition, nor solely the handiwork of the authoritarian military regime in Jakarta. It seems to be a unique blend of government initiative and local custom. The program has yet to reach a majority of Indonesian villagers and its impact on fertility, and ultimately on development, has yet to be adequately measured.

Many criticize the program and some suggest that contraceptive use may level off after the most easily motivated have been reached. To be sure, the ultimate success of family planning in Indonesia will depend on the government's ability to cope with the country's many economic and ecological problems. Yet there is some reason for optimism. Preliminary results from the Indonesian World Fertility Survey suggest birth rates have dropped faster in Java and Bali in recent years than in any other developing country save China. Instead of establishing complicated bureaucratic systems for registering births, marriages, and the distribution of contraceptives, a whole range of fertility-related activities is carried out at the community level. Some villages have acted on their own to raise the local legal age of marriage. As Haryono Suyono of the BKKBN points out, "the long term success of family planning in Indonesia hinges on the ability of the government to transfer to the individual and the community the same

sense of urgency that now exists at higher levels of government rather than simply imposing a family planning program on an otherwise uncommitted public."[42]

Less ambitious than Indonesian family planning efforts, the Mothers' Clubs of South Korea form one of the oldest and largest systems of community-based contraceptive distribution. Originally, the Korean family planning program depended on field workers who were individually responsible for reaching over 2,000 couples each in as many as 60 villages—a caseload that would make a saint flinch. To rectify this situation, the Planned Parenthood Federation of Korea reorganized and expanded its family planning services through the creation of the Mothers' Clubs.[43]

Today many women meet in the homes of their elected club leaders to receive their monthly supply of pills or condoms and to discuss the value of small families and child spacing. Though some bureaucrats in Korea's family planning program would, reportedly, like to see the Mothers' Clubs focus almost exclusively on birth control, the Clubs emphasize village economic development. According to a study conducted in 1973, three-quarters of the more than 20,000 Mothers' Clubs had established credit unions. Others had initiated reforestation projects, developed new rice lands, bought livestock herds, and opened grocery stores. While family planning programs in most developing countries are today much more effective in urban than in rural areas, the Korean program is almost equally effective in both—and the Mothers' Clubs deserve much of the credit.[44]

Not all decentralization projects have worked. In the mid-seventies the Pakistani government launched a bold contraceptive inundation program in which contraceptives were to be distributed through 35,000 shop outlets and 750 clinics, and by over 5,000 fieldworkers who were supposed to visit and advise all the married couples in their assigned area three to four times a year. The theory behind this program was that flooding the countryside with affordable birth control pills and condoms would satisfy a latent, previously unfulfilled demand for contraception and actually increase that demand. Yet, a study conducted in February 1977 by the U.S. Senate Committee on

Foreign Relations concluded, the availability of contraceptives in Pakistan has not significantly increased contraceptive use.[45]

Proponents of the Pakistani program argue that the government was simply unable to establish an effective distribution system, so supplies remained in the warehouses. Critics charge that the government is not fully committed to the program. Furthermore, many observers question whether supply creates its own demand; they argue that inundating the market with contraceptives will not significantly increase the number of couples using modern methods of contraception until couples are motivated to change their views on the number of children they wish to have.

But similar projects, often called household distribution schemes, are being experimented with in a number of countries, seemingly with more success. In Colombia, part-time family planning workers sell a variety of contraceptives to their neighbors at low cost, making a small profit on each sale. In a project in Honduras, a small group of satisfied contraceptive users are paid a monthly salary to supply other women in their community with contraceptives.[46]

These programs differ significantly from the community mobilization taking place in China and in the Mothers' Clubs in parts of Indonesia and Korea, though both styles rely on peer pressure and neighborhood structures. Household distribution schemes are designed primarily to improve the delivery of contraceptive supplies and do not attempt to motivate increased contraceptive use by linking family planning to other development activities. Similar efforts to decentralize family planning in other ways have also focused on attempts to increase access to services.

For years, family planning clinics resembled the out-patient facilities of hospitals. Those who used contraception had to seek out services as if the users were patients with illnesses. The clinic was a passive force in the community. While clinics remain the major focus of family planning activity in most countries, many governments have begun to use clinics to back up more comprehensive efforts. In 1966, several countries launched an international postpartum family plan-

ning program. Their aim was to reach women who had just given birth or who had just had an abortion in a hospital or clinic. By 1974, more than 1,700 institutions in 21 countries (including 926 in the United States) were using the postpartum approach. Encouraging patients to be sterilized, to have an IUD inserted, or to use the pill has proved successful with about one in three women in these programs.[47]

Some government health planners now consider family planning as an integral part of maternal and child health care. Studies have shown that children born to young mothers, the youngest children in large families, and children born within a year or so of their siblings often suffer from malnourishment, are susceptible to illness, and have death rates much higher than the children of women in their twenties who have spaced their childbearing. Struck by these correlations, the Cuban and Tanzanian governments have established village-level maternal and child health-care programs that include distribution of contraceptives.[48]

In those many nations in which most babies are born outside the reach of the formal medical establishment, governments are hard-pressed to build hospitals fast enough or to revamp their health strategies soon enough to meet immediate family planning needs. The demand at health clinics for curative services usually swamps doctors' best efforts to integrate family planning into full health services, especially where fully trained medical personnel are scarce. To overcome these problems, many countries are looking to indigenous midwives and to teams of health workers schooled in preventive medicine. The portion of women accepting family planning who chose the pill over less effective methods rose from 10 percent to 72 percent during the first two years that auxiliary midwives in Thailand were permitted to prescribe the pill. In addition, possibly because pill dispensers had personal ties to pill users, those recruited by the midwives tended to stay on the pill longer than those who received oral contraceptives from doctors in clinics.[49]

Outgrowing the confines of the clinic, new family planning strategies reach people where they shop, work, worship, and live. Although a

day's walk separates some communities from the nearest hospital or family planning clinic, most potential contraceptive users have daily contact with grocers and itinerant folk-medicine men. By linking up with an established commercial distribution network, family planners hope to reach a large portion of the population at a low cost. Unfortunately, marketing schemes, like household distribution strategies, already involve little longlasting motivation and can only serve those already interested in using contraception. Moreover, stories abound of condoms being sold as balloons and of shopkeepers downplaying the promotion of birth control devices. Just what contribution advertising and the commercial distribution of contraceptives can make toward filling the family planning gap remains to be seen.

One of the first major marketing programs was that started by Population Services International (PSI) in Sri Lanka and now run by IPPF. The program began in 1973 as an effort to market a condom called "Preethi"—happiness in both Sinhalese and Tamil, the two principal languages in Sri Lanka. The program distributes condoms through various commercial outlets; and the "Preethi" symbol, a stylized hand with the male genetic symbol held between the thumb and forefinger, has become as familiar as the bunches of bananas that grace the island's tea shops. By mid-1976, over 450,000 condoms were sold each month; and pills were distributed nationwide under the catchy name of "Mithuri," which means "the woman's friend."[50]

PSI claims that sales figures indicate that growing numbers of persons are practicing contraception and that more are also switching to effective means of planning family size. However, the "Preethi" campaign is aimed at those with above-average incomes; prices were set to encourage the idea that condoms have intrinsic value and to enable the program to become self-sustaining eventually. Although the poor, who would have to pay more than a day's wages for three "Preethi" condoms, are by-passed in this kind of marketing effort, such programs do meet the contraceptive needs of certain segments of society.

Similar projects have sprung up in a number of developing countries. Thailand opened what is possibly the world's first contraceptive su-

permarket in a Bangkok bus terminal in 1975; various contraceptives and educational materials are sold in the store, and a midwife-counselor doubles as a salesclerk. In Colombia social customs hindered, if not blocked altogether, access to contraceptives for years. Now pills, condoms, and contraceptive foam are familiar counter-top items in urban pharmacies and country stores. It is estimated that from 1970 to 1976, nearly half of all users of modern contraceptive methods in Colombia obtained them from commercial outlets.[51]

In the industrialized world, the commercial sale of contraceptives is restricted primarily to non-prescription methods. Door-to-door condom saleswomen in Japan generate a sizable portion of the sales of Japan's favorite contraceptive, in many cases selling directly to other women. One-third of the condom sales in England take place in barber shops, while department stores carry condoms in Sweden. In Bologna, Italy, condoms are available from vending machines on the street. In the United States, however, contraceptives are marketed less extensively. A national survey conducted in 1975 revealed that more than four of ten pharmacists refused to exhibit condoms openly, a legacy of the under-the-counter image that inhibited condom sales a generation ago.[52]

Working with youth is the focus of one decentralization effort—Grapevine, Britain's community sex education project for adolescents. Grapevine trains young volunteers to work with people their own age in coffee bars, in pubs, and on the streets. This program, which started in London, has expanded to other British towns and was recently imitated in West Germany. Because of a shockingly high venereal disease rate among students, rap sessions on adolescents' sexual problems led by volunteer peer counselors have been organized during school hours by 11 New York City high schools. Since 1974, Woodson High School in Washington, D.C. has had the only school-based contraceptive clinic in the United States; peer counseling goes on during class hours, and students can have physical examinations and obtain contraceptives from the clinic in the school at the close of the school day. So, too, many American colleges and universities have loosened their restrictions on dispensing contraceptives in student health centers.[53]

Bent upon reaching the young more effectively, many national family associations are also re-examining their internal structures. Too often, a recent study of the 12 European members of IPPF showed, policy is formulated and carried out primarily by persons over 35 years of age. Similarly, the boards of these organizations seldom have members under age 25, although adolescents are one of the main groups served by some family planning programs.

Even though all workers need contraceptives and though the number of women workers grows steadily, few employers and trade unions in the industrial world offer family planning services to their employees. Where health services do exist, family planning services usually remain outside the scope of the care provided. Job-site family planning centers are still few and far between.[54]

In the developing world, however, some employers now provide contraceptives and incentives to keep families small; studies suggest that making such services available increases worker productivity and attendance. Possibly the most innovative program involves women workers on tea estates in South India: each month during which a female employee does not bear a child, a small sum of money is put into a retirement fund for her. The program tries to get parents to space children at intervals of three or more years and to limit family size to three children. A woman forfeits part of her retirement fund if she has children in rapid succession or opts for a large family.[55]

Often the largest single employer in a developing economy, government too can sponsor work-related family planning. The Indian state railroad provides family planning services, including sterilization, for all its employees. In the Philippines, employers with more than 200 workers are required to provide free family planning services. The Coffee Growers Committee, a nationwide marketing cooperative, supplies approximately half the funds for Colombia's rural family planning program and lends legitimacy to efforts to expand contraceptive use.[56]

That organizations of all sorts can help their members plan their families is brought home by the story of the Iglesia ni Cristo, an evan-

"Sunday sermons often contain a word on child spacing, and contraceptives are distributed as the collection plate is passed."

gelical Christian denomination in the Philippines with about four million members. Since 1973, this church has preached the social and personal responsibility of its members to limit family size, and it has become the major private agency involved with Philippine family planning, running the largest male sterilization program in the country. Church-owned radio stations beam family planning messages daily. Sunday sermons often contain a word on child spacing, and contraceptives are distributed as the collection plate is passed. Church programs are also developing in other areas: in Mauritius, the Catholic Church backs programs to teach women the proper use of the rhythm method; in South Korea, the National Council of Churches has organized door-to-door contraceptive distribution and set up family planning clinics in parish halls in Seoul, Pusan, and Taejŏn.[57]

Decentralized family planning programs run the gamut from highly articulated political programs to modest efforts to improve the distribution of contraceptives. Where contraceptive use has been linked to individual social standing in the community and to personal economic improvement, preliminary studies suggest that family planning activity has risen sharply. Programs that are more supply-oriented and that involve less effort to motivate couples to practice birth control are more controversial, with successes and failures dotting the map. It may be some time before the best decentralization strategies are identified.

Filling the Gap

James Boswell, biographer of Samuel Johnson, once observed that humanity often deludes itself with "the triumph of hope over experience." In the last generation, many who were fervently committed to slowing population growth were mesmerized by their wishes and enthusiasm; struck by the urgency of what seemed to be the inescapable logic of demographic extrapolations, they often grasped for simple solutions to the complex question of why parents have large families. In the process, governments and foundations have fired salvos of money and expertise at the population problem with, until recently, relatively little success. While the rich have generally established con-

trol over their fertility, the poor, the young, the unmarried, and the rural continue to have difficulty planning their families.[58]

The several hundred million couples in the world who, without the benefit of a safe and reliable contraceptive, face the risk of an unplanned or unwanted pregnancy bear witness that there is no simple way to provide family planning services. In Asia, Africa, and Latin America, family planning still ranks with basic health care as a human service that large segments of the population do without. A couple's decision on childbearing is often taken in isolation, with little opportunity to relate it to the overall welfare of the couple involved or to the well-being of the community. Family planning remains for many a fumbling exercise of outdated, frequently futile, and often dangerous methods.

Yet two-thirds of the married women in most industralized nations use contraception. Few social service programs have progressed as rapidly as the family planning programs in rich countries, and new evidence suggests that this success is being replicated in several developing nations. While memories of dashed expectations are sobering, some tentative and hopeful conclusions can be drawn from recent family planning experience, pointing the way towards what can be done to close the family planning gap.

Attitudes about family size are critical to the acceptance of family planning. Throughout history, when couples have decided a small family was in their own interest, they have limited the number of their children despite all obstacles—albeit imperfectly and at considerable risk. The view espoused by some, that the poor bear children irresponsibly, bespeaks prejudice and misunderstanding. Large families are less the product of unrestrained fertility than of perceived parental self-interest, birth control failures, or the view that family size is beyond a couple's control.[59]

Today attitudes toward family size are in flux. Recent surveys conducted in Japan, Europe, and the United States all show that women hope to have fewer children than their mothers or even their older sisters did. Similar surveys in developing countries are inconclu-

sive, but desired family size generally remains large. The precise manner in which changing attitudes toward family size come about and how they translate into fertility decline is not fully understood. The old demographic transition theory, which suggested that birth rates fall after development has occurred, is now in question. Recent studies suggest that the connection is less direct, that fertility may fall without significant economic development, and that improvement in living standards may even encourage the formation of larger families. While this debate waxes and wanes, it would appear that organized family planning programs work best in countries where average income is highest, where the distribution of social services is relatively equitable, and where economic and social reforms have given the poor new opportunities.[60]

If any lesson can be learned from past experience, it is that inadequate health care, education, housing, nutrition, employment, and family planning are all aspects of the same affliction—whose symptoms cannot be treated in isolation. China's rapidly declining birth rate, for example, reflects a combination of radical social changes made for the overall benefit of the majority of the people. Despite administrative difficulties, the most successful development efforts and family planning programs have been those that addressed a whole range of problems comprehensively and simultaneously.

Family planning action is required on several fronts. Since 1970, international financial resources available for family planning have more than doubled. But even these dramatically expanded resources have not been able to keep up with the demand from national governments for funds. While some of this demand no doubt represents a willingness to take advantage of any available international development assistance, the actions of many governments suggest that their commitment to family planning has deepened. Throwing money at the population problem will not solve it, but censuses and family planning programs conducted as part of overall health care and development strategies do cost more than many poor governments can afford. The major international donors may well need to double the sums they now give; indeed, at least 400 million dollars a year for the next ten years could be put to efficient and effective use, according

to UNFPA and AID. These levels of assistance could, of course, decline as countries begin developing self-sufficient family planning programs, producing their own contraceptives and funding their own distribution programs.[61]

Developing effective programs and creating a legal and social atmosphere in which family planning has a chance to work requires strong government support. Between 1974 and 1976, more than 40 governments took steps either to update existing family planning laws and policies or to introduce new ones. At the same time nations began to change laws and social customs, such as the age of marriage and the role of women in society, that affect fertility. Fewer governments, however, have backed innovative development strategies that encourage fertility decline or have committed the resources necessary to launch a broad-based effort to fully educate the public about the consequences of rapid population growth.[62]

To date the most successful family planning programs have been the most decentralized ones. They have shown that they can win over more people to contraceptive use, achieve higher contraceptive continuation rates, and cost less than conventional efforts. Most of these programs have focused on improving supply lines. Supporters of improved distribution efforts assert that the first task of both international and national programs is to provide contraceptives to those who want them. Yet many observers believe that complementary efforts to increase the number of people who desire the services are even more necessary. But these two approaches need not clash. New supply outlets include many organizations—churches and industries—that should be viewed as little communities, and new motivational strategies can often exploit peer pressure in these groups to change attitudes about family size.

Such peer reinforcement is commonly found where birth rates are falling. In both the birth planning committee meeting in the Chinese village and the rap session in the American college dormitory, the opinions of peers prompt both men and women to examine seriously their expectations about family size.

Success in such efforts depends on working with well-organized communities. Wherever possible, family planning programs should work with groups that possess an internal administrative structure or an informal means of social control over their members and with groups whose constituents have shared interests. Where this has happened, the groups involved have been strengthened, developing new administrative and organizational skills that they put to good use. For example, in Indonesia many *Apsari* have already begun to pressure the government to expand its other development projects. Self-help family planning programs can be linked to self-help housing, health care, food production, and education efforts to encourage individuals and communities to master their personal and collective destinies.[63]

Where strong community organizational structures do not exist, government policies should help foster them. Most specifically, governments might extend to whole communities that cooperate in family planning ventures economic benefits similar to those now offered in many countries to couples. Such group incentives—a village well, a new school, or a better road—can often capitalize on peer pressure to encourage communities to work together to reach specific population growth targets.

Yet peer pressure can only go so far, especially in large communities that are not socially and politically cohesive. In many villages, racial and ethnic splits may stymie efforts to utilize broad-based peer pressure. The social disruption brought about by recent massive migration to urban centers in developing countries has compounded the difficulty of effectively organizing slum dwellers. In India, the divisions of caste and clan make such appeals in development efforts difficult. Clearly, Chinese-style or Indonesian-style peer pressure will not always work.

Political reform, international and national commitment, and local involvement must undergird successful family planning strategies. But all this will come to naught unless legal abortion and a wide range of contraceptive methods are made available. Among developing nations, only China, Singapore, and South Korea now permit unencumbered access to abortion, sterilization, the pill, and the IUD. Even

in rich countries, several million women each year have unplanned pregnancies because modern means of contraception are not easily obtainable. Providing couples with the wherewithal to plan their families safely and effectively is certainly an important element in changing fertility patterns.

Just as there is no one best contraceptive, there is no single way to fill the family planning gap. Each country must find its own path, designing programs that are sensitive to the cultural, political, and economic realities it faces. In some societies, this may mean improving the supply and choice of contraceptives; in others, it may entail working with local groups and using peer pressure to help change attitudes about family size. But the most successful programs will be those that link supply and motivation.

The reason for hope that the initiatives outlined here will succeed springs out of the fresh political climate surrounding family planning. At the World Population Conference in Bucharest in 1974, many governments vented pent-up frustrations born of development programs that had failed to reach the poorest of the poor and of population programs that slighted economic and social change. The debate that ensued cleared the air. In many societies, for the first time, family planning and development are no longer an either/or proposition. The rhetoric has begun to turn to action as couples in both rich and poor countries relate their personal childbearing decisions to their nation's, their community's, and their family's well-being.

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